Medicare Reimbursement for Telehealth

An Assessment of Telehealth Encounters
January 1, 1999 – June 30, 1999

Preliminary Report – October 15, 1999

Joe Tracy, Director of Telemedicine
University of Missouri Health Sciences Center

Thelma McClosky-Armstrong, Director
Eastern Montana Telemedicine Network

Rob Sprang, Director
Kentucky Telecare

Sam Burgiss, PhD, Director
University of Tennessee Telemedicine Network

Introduction

The Balanced Budget Act (BBA) of 1997 mandated that the Health Care Financing Administration (HCFA) begin reimbursing for select telehealth consultations on January 1, 1999. This was an important first step in recognizing telehealth as a reimbursable service, but there are serious flaws in HCFA's approach. Recognizing that HCFA's rules remain in an evaluation period and that three federal bills (HR1344, S980 & S770) have been introduced that would enhance those rules, the authors conducted an assessment of telehealth patient care encounters from the period January 1, 1999 through June 30, 1999. The results of that assessment are provided in this document.

An assessment instrument was created and sent to telehealth projects on August 16, 1999 via the telehealth listserve managed by the University of Missouri Health Sciences Center. Below are some preliminary analyses of the results. A more detailed report will be released at a later time.

Preliminary Results:

- Approximately 35 telehealth networks received the assessment and 20 networks provided responses.

- The 20 responding telehealth programs accounted for 4,761 telehealth encounters between January 1, 1999 and June 30, 1999. This number includes physician to physician consultations, patient to physician encounters, occupational therapy, speech therapy, physical therapy, clinical psychologist services and other activities not directly captured by the assessment.

- The average number of encounters per network was 238, and the median was 183. Encounters ranged from a low of 14 to a high of 581.

- Only 231 or 4.9% of all activities involved physician to physician consultation, and of these 34 involved Medicare consults. *This suggests telehealth sessions involving physicians on both ends are the exception and not the rule.*

- A total of 3,865 or 81% of the activities involved physician-to-patient encounters and of these, 529 were reported to involve patients who would have been covered by Medicare if the care had been delivered in person. *This suggests that telehealth provides far more direct patient care encounters than consultations between clinicians.*

- Combining the data for physician to physician consultations and patient to physician encounters totals to 4,096 activities of which 563 (13.7%) were Medicare.

- Only 119 of the 563 Medicare cases were reported as billed, and only 36 of those had been paid. Seventeen of the 20 responding networks operate under the normal HCFA reimbursement rules and three other networks are covered by a special Medicare waiver as part of HCFA's telehealth study. These seventeen networks accounted for 416 of the 563 Medicare encounters, but only 43 of those billed. *This provides further evidence that the vast majority of real-world telehealth encounters are systematically excluded by current HCFA reimbursement rules.*

- The median number of round trip miles that the typical Medicare beneficiary would have traveled to an urban center if telehealth facilities were not locally available was 197 miles. *Based on the Federal reimbursement rate for mileage at .31 per mile, vehicular travel for the typical Medicare patient would cost that patient approximately $61 per trip, and this does not account for meals, lodging, time away from work, etc.*

- 17 networks provided information on patients living in or using telehealth facilities that are located in a federally designated Health Professional Shortage Area (HPSA). The total number of telehealth encounters at these 17 sites was 4,002. Of those encounters 1,018 or 25.4% were patients living in or using telehealth facilities in HPSA areas. Applying this percentage to the number of Medicare cases in this study indicates that approximately 141 of the 563 cases would be eligible for HCFA reimbursement **if** the HPSA requirement was the only criteria to be met. On the other hand, 422 of these Medicare cases would be automatically ineligible for reimbursement because they would not have met the HPSA criteria. *A legislative change to the BBA would be needed in order for HCFA to expand reimbursement beyond the HPSA designation as suggested in H.R. 1344, S. 770 and S. 980.*

- 171 or 3.6% of all encounters involved patient interaction with either an occupational, physical, speech therapist or clinical psychologist. *Such encounters are not reimbursable under the current HCFA rules but would be in a traditional face-to-face encounter.*

- 328 or 6.9% of all encounters involved a patient telepresenter who was the referring practitioner or an employee of the referring practitioner who is eligible to be a referring practitioner. This suggests that if all of the reported 4,761 telehealth activities were Medicare, less than 7% of all cases would meet the criteria for being reimbursed simply because of who HCFA designates as an eligible patient presenter. HCFA currently excludes LPNs and RNs as eligible patient telepresenters. However, LPNs and RNs make up the majority of patient presenters in almost all telehealth networks. *HCFA has the flexibility to include LPNs and RNs as eligible telepresenters and they should be encouraged to make those additions to the eligible telepresenter list.*

- 16 or 80% of the telehealth network directors felt that there would be no objection by rural physicians, administrators, or other health professionals to the removal of the fee split requirement from the BBA and HCFA rules. *Removal of the fee split would require a legislative change to the BBA.*

- 18 or 90% of the networks indicate that their computer systems are not designed to handle the 75% - 25% fee split. *HCFA has placed the administrative burden for the fee split on the clinician remote from the patient.*

- 16 or 80% of the directors report that their clinical specialists will not accept 75% of the normal fee they would have received had the patient traveled to their office and one network was unsure.

- 4 or 20% of the directors said that at least one third party payor in their area that was already paying for telehealth services has adopted the HCFA reimbursement model. *To the extent such conversions continue many programs now receiving private payment for many telehealth encounters will be adversely impacted by the decision to use the HCFA model which is very limiting in what can be reimbursed.*

- 17 or 85% of program directors said that telehomecare should be a covered service while the remaining 15% were unsure or did not respond to the item. *Telehomecare is not addressed in the BBA or HCFA rules but holds great promise for delivering care to patients in their home, which is a less expensive environment in many instances.*

- 14 or 70% said the patient should be allowed to act as their own presenter in telehomecare encounters. Only one site indicated they felt such a presentation was not appropriate and the other 5 were uncertain as to whether or not to allow the patients to present themselves to the clinician. *Allowing patients, family members, etc., to act as patient presenters when appropriate may reduce the number of necessary home health nursing visits and drive down costs while improving access to needed care.*

- 14 or 70% indicated that the use of store and forward technologies for telehealth should be reimbursed and that interactive video should not be a requirement when using such technologies. Store and forward technologies produce very high quality video and still imaging. These images can be transmitted and stored at the urban center where they can be reviewed and interpreted in non-urgent situations. These technologies hold great promise because they do not require broadband telecommunication services which is especially important to those living in areas where such telecommunication services still do not exist.

- 15 or 75% of the responding directors felt that it would be appropriate for the rural site to have the option of charging the Medicare beneficiary a facility fee in lieu of the transportation savings that would be accrued by the patient. The median recommended fee by these directors was $20 per encounter. *A legislative change to the BBA would be needed in order for rural sites to have this option. The option to charge the patient a facility fee puts the decision to use or not use the telehealth facility squarely on the Medicare beneficiary. The patient has the option to travel to the urban facility for care or to use the telehealth network. Choosing to use the telehealth network has the potential to save them a great deal of travel expense and time, especially since the median value of vehicular transportation is calculated in this study to be approximately $61 per trip not including meals, time away from work, etc.*

Summary

The preliminary results of this assessment indicate the following:

- Changes to both the BBA and HCFA reimbursement rules are necessary if telehealth services are to level the playing field in terms of access to healthcare services for all Americans no matter if they choose to live in urban or rural areas of the United States.

- The current HCFA reimbursement rules and certain parts of the BBA have created an environment whereby HCFA will never collect enough timely data to determine the cost impact telehealth services may have on the Medicare program. The reason for this stems from the fact that if a telehealth facility cannot meet the complex criteria for generating a Medicare bill then it would be a waste of time, effort and money to generate a claim that has no chance of being paid.

- Clinician to clinician consultations via telehealth networks is the exception and direct interaction between physician and patient is the rule. However, the HCFA reimbursement rules only reimburse for the exception.

- The use of the referring practitioner or employee of the referring practitioner (that is eligible to be a referring practitioner) to present the patient is **not** how most networks deliver telehealth services. The use of RNs, LPNs or other health professionals to present the patient to the clinician remote from the patient is how most networks deliver telehealth services.

- The HPSA criterion appears to have a substantial impact on the number of telehealth encounters that can be reimbursed. Using the HPSA designation as a requirement for reimbursement of telehealth services is flawed because HPSAs measure the total number of clinicians in a rural area, not just the number of physicians. As most services provided via telehealth networks are more specialized in nature and HPSAs do not specifically account for this, a rural patient's access to care is not being accurately represented. In order to service rural areas, a better definition of rurality is needed. This can be accomplished by changing the designation of a rural area, as suggested in S. 980, S. 770 and H.R. 1344, to include those areas that are not Metropolitan Statistical Areas (MSAs). By changing this designation, patients in truly rural areas will have access to appropriate levels of health care.

- A large majority of the directors who completed the assessment are in favor of eliminating the fee-sharing requirement, adding telehomecare to the list of reimbursable services, and adding store and forward to the list of approved telehealth services.

- Allowing the rural telehealth site the option to charge the patient a $20 fee for the use of the facility would save the typical rural beneficiary (or their family, church, civic organization or other entity that helps pay the patient's cost of travel) about $41 in transportation fees alone. Such a charge would help offset some of cost of the service for the rural site and would in effect negate the need for the 75%-25% fee split that was designed to reimburse the rural end of the telehealth encounter. Based on the Federal reimbursement rate of .31 per mile the recommended $20 fee would immediately offset the transportation costs for Medicare beneficiaries traveling only 65 miles round trip to see a clinician. Making this charge optional, or payable on a sliding fee scale, at the discretion of the telehealth program also allows the presenting facility some flexibility to deal with patients on a case by case basis. It also provides the beneficiary with the choice to use the telehealth facility or travel to see the clinician. Patient choice is something that needs to be maintained not regulated.